HEALTH AND SENIOR SERVICES

DIVISION OF HEALTH CARE QUALITY AND OVERSIGHT

HOSPITAL FINANCIAL REPORTING AND SUPPORT

Hospital Financial Reporting

Proposed Readoption with Amendments: N.J.A.C. 8:31B

Authorized By: _____

Fred M. Jacobs, M.D., J.D., Commissioner,

Department of Health and Senior Services (with approval of the

Health Care Administration Board)

Authority: N.J.S.A. 26:2H-1, et seq.

Calendar Requirement: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2005 -

Submit written comments by _____ to:

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The agency proposal follows:

Summary

In accordance with N.J.S.A. 52:14B-5.1c, N.J.A.C. 8:31B, Hospital Financial Reporting, is scheduled to expire on July 24, 2005. The Department of Health and Senior Services ("Department") has reviewed N.J.A.C. 8:31B and, with the exception of the amendments described below, has determined the existing rules to be necessary, adequate, reasonable, efficient, understandable, and responsive to the purposes for which they were originally promulgated.

Mandating data submissions from hospitals began in 1971 with the Health Care Facilities Planning Act (N.J.S.A. 26:2H-1 et seq.), which mandated a uniform system of cost accounting for health care services. The Acute Care Hospital Cost Reports were developed in 1974 for the Standard Hospital Accounting and Rate Evaluation (SHARE) hospital reimbursement system.

Modifications in 1980 occurred as a result of the adoption of the all-payer hospital reimbursement system, mandated by P.L. 1978, c.83 (Chapter 83), which replaced the SHARE system in 1980 and established hospital inpatient rates based on Diagnostic Related Groups (DRGs).

Hospital reimbursement was deregulated effective January 1, 1993. Nonetheless, the Health Care Reform Act of 1992 (P.L. 1992, c.160) (Chapter 160), retained the requirement of the Health Care Facilities Planning Act that

hospitals submit cost reports and financial statements to the Department. The cost report forms retain elements necessary for calculating Medicaid fee-for-service inpatient rates, various hospital subsidies from the Health Care Subsidy Fund, including those provided for by Chapter 113 of P.L. 2004, and fees mandated by N.J.S.A. 26:2H-18.57 and N.J.S.A. 26:2H-18.62, both amended by P.L. 2004, c. 54, that hospitals remit to the Department to fund various health initiatives. Moreover, the Department's central role in protecting access to quality health services in the State requires timely, reliable information on the financial condition of hospitals.

The Hospital Financial Reporting chapter comprises five subchapters: General Provisions, Hospital Reporting of Uniform Bill Data, Financial Monitoring and Reporting Regulations, Financial Elements and Reporting, and Standards for Hospital Notification Regarding Offset of Medicaid Payments and Charity Care Subsidy Payments to Collect Hospital Debts Due to the State.

The Department is proposing a number of technical and grammatical amendments throughout the chapter to correct errors and to improve the precision of language used. For example, the Department is proposing the uniform use of the term "shall," when designating a mandatory requirement, as opposed to mixing the use of the term "shall" with a synonymous term like "must." The term "shall" is commonly used in this respect throughout the State's rules and laws. It is the Department's hope that consistent use of the word "shall" when a particular requirement is mandatory, rather than interchangeably using the term "shall" with a synonymous term like "must," will eliminate any potential

confusion regarding the meaning of such provisions throughout the chapter. These types of technical and grammatical changes would not modify the existing meaning of the rules.

The Department is proposing to amend the heading for N.J.A.C. 8:31B so as to reflect a change in organizational designation. Specifically, whereas the program which administers this rule was formerly known as Hospital Financing Systems, it is now Hospital Financial Reporting and Support. The Department, therefore, proposes that the heading be changed from “Hospital Financing” to “Hospital Financial Reporting.”

N.J.A.C. 8:31B, Subchapter 1, General Provisions, specifies the purpose and scope of the chapter, and the definitions of frequently used terms. The Department proposes amendments to this subchapter to include citations to new laws which amend the Health Care Facilities Planning Act (N.J.S.A. 26:2H-1, et seq.). Specifically, the Department proposes adding citations to P.L. 1998, c. 43, P.L. 2004, c. 54 and P.L. 2004, c. 113. In addition, the Department proposes amending the definition of the term “hospital” in order to ensure consistency with P.L. 2004, c.54, Section 2, and proposes amending the reference to uniform billing forms from “UB-82” to the more generic “UB” to obviate the need for future rule amendments due to changes in form number assigned by the National Uniform Billing Committee.

N.J.A.C. 8:31B, Subchapter 2, Hospital Reporting of Uniform Bill Data (Inpatient, Same-Day Surgery and Emergency Department Outpatient), provides for a standard patient-level data reporting system. The Department began

collecting patient billing data as part of the 1978 reimbursement system to set inpatient rates based on diagnosis. This information is still collected from all licensed general acute care hospitals in New Jersey, as well as certain special hospitals, and is used to set Medicaid fee-for-service rates. The Department also uses the data to analyze hospital market share, treatment patterns, patient demographics and other public health issues. After safeguarding the confidentiality of Protected Health Information in accordance with federal and State rules, the Department makes these data available to the public for clinical and financial analyses.

This subchapter incorporates the National Uniform Bill as the format for reporting to the Department billing data for all inpatients, same-day surgeries, and emergency department outpatients. In addition, the subchapter describes data intermediary duties, data submission schedules, editing, costs, and penalties for late submission of data.

The National Uniform Billing Committee (NUBC) determines the data requirements and design of the standard format used nationally to report billing data, called the National Uniform Bill. The NUBC commonly refers to the National Uniform Bill as "UB-82," "UB-92," or "HCFA-1450." N.J.A.C. 8:31B, Subchapter 2, which incorporates the National Uniform Bill as the format for reporting billing data for all inpatients, same-day surgeries, and emergency department outpatients to the Department, refers several times to the National Uniform Bill using these shortened names.

Proposed amendments to Subchapter 2 would allow incorporation of the most recent and all future versions of the National Uniform Bill, and would adopt the updated version(s) upon 60 days notice by the Department that it has been implemented for the Department's electronic discharge data collection system. Accordingly, the Department proposes to replace the terms "UB-92" and "HCFA-1450" with "most recent version of the UB" or "UB," as appropriate, throughout this subchapter.

In addition, the Department proposes to delete the words "Civilian Health and Medical Program for the Uniformed Services" (CHAMPUS) and add the word "TRICARE" to the CHAMPUS category in Subchapter 2 because the federal government has replaced the CHAMPUS program with TRICARE. The Department also proposes to add the name of the Medicaid program because the NUBC has guidelines for completing UBs for that payer. Another proposed amendment would remove a previous street address for the Hospital Financial Reporting and Support program. The post office box that remains is the correct mailing address.

N.J.A.C. 8:31B, Subchapter 3 (Financial Monitoring and Reporting Regulations) and Subchapter 4 (Financial Elements and Reporting) describe the financial and utilization data requirements, submission schedules, penalties for late submission, general guidance, and guidance on specific data elements. The required annual cost report data include cost, revenue and statistical data. Certified, audited financial statements provide verification for data contained in the cost reports. Annual data are used as source data by the State agencies to

set Medicaid fee-for-service inpatient hospital rates, calculate various subsidies, and to assess hospitals in accordance with P.L. 1992, c. 160, as amended by P.L. 2004, c. 54. Quarterly data are used to monitor the financial stability of hospitals and access to health services in the State.

The Department proposes to amend N.J.A.C. 8:31B, Subchapter 3, to indicate that the data requirements would not exceed the data currently found on the L-1, L-3 forms, and that on the B-2 (utilization data) form. The Department would retain discretion to adopt format and specifications. The proposed amendments to Subchapter 3 would insert specific reference to the B-2 form because readoption of these rules in 2000 failed to specify that the previously required quarterly B-2 form submission became part of the quarterly financial data submission. The proposed addition of the words “utilization data” throughout Section 3.3 would require that the quarterly data submission contain the utilization data identified on the B-2 cost report form. These data are required to understand hospital financial performance. The proposed amended language indicates that penalties for late submission of data also would apply to the B-2 form.

Each year a number of hospitals fail to submit cost reports on a timely basis, which creates problems for auditing and the proper calculation of charity care subsidies and hospital assessments. To deter noncompliance, proposed amendments to N.J.A.C. 8:31B-3.3(c) would raise the maximum penalty for late submission of annual cost report data from $100 per day to no more than $1,000 per day, in accordance with N.J.S.A. 26:2H-18.59c. In addition to increased

monetary penalties, proposed amendments to N.J.A.C. 8:31B-3.16(c) would establish that, as a consequence for failing to submit annual cost report data prior to August 31 of the current reporting year, the Department would enter zero dollars as the hospital's total gross revenue for all patients in the Aggregate Current Cost Data Base for the purpose of calculating the charity care subsidies provided for in P.L. 2004, c. 113. Proposed amendments to N.J.A.C. 8:31B-3.16(d) would restrict the basis for appeal of the Department's zero gross revenue default decision to a challenge of the date of receipt by the Department of the annual cost report data.

The Department is proposing to amend N.J.A.C. 8:31B-3.25(a) to correct the spelling of the term "net gain." Proposed amendments to N.J.A.C. 8:31B-3.25(d) would replace reference to "SHARE" with "New Jersey Acute Care Hospital Cost Report," because "SHARE" refers to an outdated term from the rate-setting era that ended in January, 1993.

Throughout N.J.A.C. 8:31B-3, references to hospital rate-setting provisions in expired N.J.A.C. 8:31A are proposed for deletion. The Department of Human Services establishes fee-for-service hospital inpatient Medicaid rates in accordance with N.J.A.C. 10:52, employing Acute Care Hospital Cost Report data. The Department proposes to amend N.J.A.C. 8:31B-3.26 to eliminate descriptions of economic, cost, and technology factors that neither the Department nor the Department of Human Services have used since the end of hospital rate-setting in 1993.

The Department proposes to amend N.J.A.C. 8:31B-3.66, Health Planning Fees, to change the heading to “Adjusted Admission Assessment”, and to correct the erroneous characterization in the present rule of the per adjusted admission assessment as $5 instead of the $10 that has been required by N.J.S.A. 26:2H-18.57 since January 1, 1994. Hospitals have been assessed and paying the $10 per adjusted admission required by the law since 1994. The law specifies that $5 of the fee is to be used by the Department for health planning purposes, and $5 for duties related to administration of P.L. 1992, c. 160, concerning hospital charity care. Since there is no other mention of this assessment in the Department’s rules, the Department has concluded that it is confusing to have a rule referencing only the $5 health planning component of the assessment. With the proposed amendments, the rule would correctly correspond to the statute. The proposed amendments also would indicate that adjusted admission fees will be assessed annually on a calendar year basis to reflect current practice, would substitute “general” for “acute care” hospitals to reflect the entity referred to in licensure rules, and would add specialty heart hospitals to be consistent with the description of affected hospitals in P.L. 2004, c. 54. Proposed amendments to N.J.A.C. 8:31B-3.66(b) would indicate that, in the event the hospital has not submitted its required cost report by the time the Department calculates the assessment for the following year, the Department would use the prior year’s assessment, increased by 15 percent.

Pursuant to N.J.S.A. 26:2H-18.62, as amended by P.L. 2004, c. 54, Section 2, the Department proposes a new section, N.J.A.C. 8:31B-3.67, to

reflect in regulation the implementation of the 0.53 percent assessment on hospital revenues that has been in place for over a decade. Subsection 3.67(a) would indicate that each general hospital and specialty heart hospital will be assessed annually 0.53 percent of its total operating revenue as reported in its most recent New Jersey Acute Care Hospital Report, and that the Department will prorate all assessments so as not to exceed the statutory limit of $40 million to be assessed annually for all covered hospitals. The proposed language would also indicate that a hospital's total operating revenue is to include revenue from any ambulatory care facility licensed to the hospital as a hospital-based, off-site ambulatory care services facility, and that, in the event a hospital has not submitted its annual cost report due on June 30 by the time the Department calculates the 0.53 assessments for the following fiscal year, the Department shall use the hospital's prior year's assessment, increased by 15 percent. Proposed Subsection N.J.A.C. 8:31B-3.67(b) would provide for a reallocation of the resulting shortfall among all remaining hospitals should a previously assessed hospital close during the assessment year. N.J.S.A. 26:2H-18.62, as amended by P.L. 2004, c. 54, Section 2, authorizes the Commissioner to determine the manner in which the assessment is made. Because the Department is proposing to prorate each hospital's assessment to avoid exceeding the $40 million annual limit, closure of a previously assessed hospital would result in a reduction of that hospital's assessment for the State fiscal year, and a total assessment amount less than the $40 million limit. The Department would, under the proposed amendment, reallocate the difference among all

remaining hospitals to retain the $40 million limit. This proposed amendment would reflect current Department practice.

The Department proposes to delete N.J.A.C. 8:31B, Sections 3.76 through 3.82, Necessity and appropriateness of health care services. These sections contain utilization review and management requirements related to hospital rate-setting regulations that expired in 1995 and were, in any event, no longer applicable after the end of hospital rate-setting in January, 1993. Separate rules governing utilization review are found in the Medicaid program.

The Department proposes to reorganize N.J.A.C. 8:31B-4, Financial Elements and Reporting. The current subchapter is organized into five parts; the Department is proposing to consolidate Parts II through V into a single Part II to be entitled “General Guidance.” The current organization reflects the rate-setting regulations which expired in 1995 and were, in any event, no longer applicable after the end of hospital rate-setting in January, 1993. A summary of the proposed reorganization of Subchapter 4 appears in the table below:

<table>
<tr><th colspan="2">Current Organization of Subchapter 4,
Financial Elements and Reporting</th><th>Proposed
Reorganization</th></tr>
<tr><td>Part I:</td><td>REPORTING PRINCIPLES AND CONCEPTS</td><td>Unchanged</td></tr>
<tr><td>Part II:</td><td>FINANCIAL ELEMENTS</td><td rowspan="3">New Part II:
GENERAL
GUIDANCE</td></tr>
<tr><td>Part III:</td><td>NATURAL CLASSIFICATIONS OF EXPENSE</td></tr>
<tr><td>Part IV:</td><td>RECONCILIATION OF COSTS AND REVENUES
RELATED TO PATIENT CARE WITH HOSPITAL</td></tr>
</table>

	UNRESTRICTED FUND EXPENSES AND REVENUES	
Part V:	DEFINITION OF COST AND REVENUE CENTERS	

The Department proposes to amend N.J.A.C. 8:31B-4 to delete obsolete references to hospital rate-setting rules in N.J.A.C. 8:31A, which expired in 1995 and was, in any event, no longer applicable after the end of hospital rate-setting in January, 1993. In addition, proposed amendments to this subchapter would include citations to newer laws which amend the Health Care Facilities Planning Act (N.J.S.A. 26:2H-1, et seq.). Specifically, citations to P.L. 1998, c.43, P.L. 2004, c. 54 and P.L. 2004, c. 113 would be added throughout as appropriate.

The Department proposes to amend N.J.A.C. 8:31B-4.6(a) by adding language that would allow the Department to adjust the most recently submitted data pursuant to N.J.A.C. 8:31B-3.16, 3.66 and 3.67, as applicable, if, as current language requires, a hospital fails to give the required six months of notice to the Department. Changes in reporting periods affect hospitals' data, and consequently, calculations of its subsidies, health planning fees and 0.53 assessment. The proposed new language would indicate that data from a previous year would be subject to audit adjustments in the same way as current-year data. In addition, the proposed amendments would replace the term "Current Cost Base" with "Acute Care Hospital Cost Report" to reflect the current name of the reporting form. Furthermore, proposed amendments to this section would clarify that financial data would be due to the Department each June 30 of

the calendar year following the hospital's fiscal year end. For hospitals with fiscal years other than a calendar year, the effect of the change would be to provide no less than six months to prepare and submit their reports. As currently written, hospitals with a fiscal year end of March 31 would have only three months to submit financial data to the Department.

The Department proposes to amend a reference related to interfund transactions in N.J.A.C. 8:31B-4.14(f) (iii) to correct a reference to a nonexistent paragraph. The Department proposes to amend a reference to charity care in N.J.A.C. 8;31B-4.15(a)(8) that would correct a reference to a reserved section.

The Department proposes to correct a grammatical error in N.J.A.C. 8:31B-4.21(g)(4)(iii). Specifically, the word "of" would be inserted in the first sentence so it would read: "This shall be the required Capitalization Policy for the reporting of assets acquired. . ."

The Department proposes deletions in subparagraph 4.21(g)6ii to correct a typographical error (an unnecessary "or") and to correct an outdated reference to the 1978 revision to the cost report filing because the intent is to require for the most recent cost report filing use of the most recent specified guidelines.

Proposed amendments to N.J.A.C. 8:31B-4.23 would place footnoted material citing the contact information for the American Institute of Certified Accountants (AICPA) into the body of the rule text and delete the footnote.

Proposed amendments to N.J.A.C. 8:31B-4.25, Related organizations, would add a statement that hospitals frequently use self-insurance trusts and captives to manage their insurance obligations. These entities are commonly

used by New Jersey hospitals as vehicles for malpractice and other insurance, and the reporting requirements of the New Jersey Health Care Facilities Financing Authority (NJHCFFA) apply to such entities. The proposed amendment would require hospitals to indicate that they are in compliance with the NJHCFFA reporting requirements. Another proposed amendment would replace an incorrect address for the AICPA and provide its website address.

A proposed amendment at Section 4.35 would remove from the definition of a research program the need for Commission approval. The Commission refers to the rate-setting Commission, which was abolished in 1993. Another proposed amendment would delete reference to "Part IV" of Subchapter 4, which is proposed for combination under Part II, as described above.

A proposed amendment at Section 4.38 would correct references to the rules governing eligibility for the charity care program to N.J.A.C. 10:52-11. Deletions at Paragraph 4.38(a)3 remove obsolete costing of charity care for outpatient renal dialysis as the lower of Medicaid or Medicare rates. The practice has been to set renal dialysis rates according to the usual Medicaid outpatient pricing, which is consistent with the statutory requirement at N.J.S.A. 26-2H-18.59i to price hospital charity care at the Medicaid rate. The previous readoption in 2000 failed to delete this methodology, which may have been used during the rate-setting era.

The Department proposes amendments at Section 4.40 that would avoid duplicative data collection of demographic information related to bad debt and charity care patients. Proposed new language would state that the statutory

requirement to collect such demographic information for charity care patients would be met through information submitted on charity care claims by hospitals to the Department's fiscal intermediary for charity care. Information on two data elements not collected on charity care claims, marital and employment status, could be collected from any available source.

Proposed amendments in Sections 4.42, 4.44, 4.46 and 4.47 would delete obsolete requirements related to hospital rate-setting regarding capital facilities allowance, major moveable equipment, reasonable working capital, and return on investment. These subchapters discussed Department uses of data as part of setting hospital rates, not how hospitals should report data on the cost report forms. With the statutory end of rate-setting in 1993, these rules have no effect. Language pertaining to recording major moveable equipment data in the cost reports is proposed for relocation to the section on major moveable equipment in Section 4.59.

The Department proposes to amend N.J.A.C. 8:31B-4.51 to correct the misspelling of "remuneration" in this section.

A proposed amendment at Section 4.52 would add the Doctor of Dental Medicine (D.M.D.), which was overlooked previously, to the list of degrees that define the term "physician". Proposed deletions starting at Section 4.52, and throughout the remainder of Subchapter 4 would replace references to obsolete Medicare Health Insurance Manuals (HIM) with the address for the Medicare website for the manuals that are based on current Medicare regulations. The Centers for Medicare and Medicaid Services, formerly the Health Care Financing

Administration, replaced the numbered HIM hardcopy documents with manuals for each type of health care provider and makes them available on the CMS website.

The proposed amendment at Section 4.59 would add language moved from Section 4.44 on major moveable equipment related to recording data in the annual cost reports.

A proposed change to Section 4.61 corrects a reference from “N.J.S.A.” to N.J.A.C. 8:31B-4.131.

Proposed amendments at Paragraph 4.61 (c)1. and Section 4.62 would revise the category of “Excluded Health Care Services” to “Separately Reported Health Care Services.” The costs and revenues of services that had been called “excluded” in practice are not excluded, but are reported separately in cost reports to allow the Department of Human Services to add or exclude as it deems appropriate to the costs and revenues underlying its Medicaid rates.

Other proposed amendments to Section 4.62 would update the names of licensed services from “long term psychiatric care” to “psychiatric care” and “long term rehabilitation and intermediate care services” to “comprehensive rehabilitation services”. The proposed new names represent the current terminology for these services used by the Department in its licensure rules. The Department also proposes an amendment that would delete references to Medicare cost funding SSA-2552 or SSA-2551, because these forms are no longer exist. The Department would delete the reference to N.J.A.C. 8:31B-3.19(c), because it is reserved. The sentence, “The acquisition costs incurred

should be accounted for in accordance with the definition of the Organ Acquisition cost center (see N.J.A.C. 8:31B-4.97) but not referenced therein," and the following "However," would be deleted, because N.J.A.C. 8:31B-4.97 refers to blood banks and not organ donation, and nowhere else in the rules is organ donation discussed.

The Department proposes amendments at Section 4.67 and Paragraph 4.72(a)3 that would correct misspellings and incorrect punctuation. "Net of funding raising costs" would become "net of fundraising costs"; "collecting sputum, urine; and feces samples;" would become "collecting sputum, urine, and feces samples;" and "monitoring of vital life sign" would become "monitoring of vital life signs".

The Department proposes an amendment at Paragraph 4.82(a)2 that would add the (CLN) abbreviation to explain the abbreviation as it appears on the cost report form.

The Department proposes an amendment at Paragraph 4.95(a)1 that would remove an unnecessary comma from the words "optimum functioning".

A proposed amendment at Subsection 4.108(a) would insert the word "per" after "reported" to indicate that reporting should be in accordance with N.J.A.C. 8:31B-4.131.

Proposed additional language in Section 4.118 would include "Collection Agency Costs" as part of Administrative and General costs, consistent with the provisions of Subparagraph 4.15(a)10.i. This proposed amendment clarifies for

those hospitals that use collection agencies that they should record those costs under general and administrative services.

N.J.A.C. 8:31B-5 sets forth the standards for hospital notification regarding offset of Medicaid payments and charity care subsidy payments to collect hospital debts due to the State. The Department proposes no changes to this subchapter on readoption.

As the Department has provided a 60-day comment period for this notice of proposal, this notice is excepted from the rulemaking calendar requirements, pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

N.J.A.C. 8:31B is designed to gather comprehensive and comparable hospital data, which provide governmental agencies and the public with valuable information for tracking and analyzing health care costs and utilization patterns. These data are also used to implement statutory assessments on hospitals, and as source data in the calculation of hospital subsidies and Medicaid fee-for-service hospital inpatient rates. Because of the multiple uses of these data and their impact on the hospital industry as well as the State Medicaid program, assuring the accuracy and timeliness of this data promotes the public's interests.

This readoption updates, clarifies, and corrects the process for submission of complete and accurate data which will support health care policy research and evaluation and will be available to interested public and private parties. Accurate, timely data are crucial to effective analysis and decision making. Patient

confidentiality will continue to be protected in accordance with HIPAA and State laws.

Economic Impact

The proposed readoption with amendments of N.J.A.C. 8:31B should have minimal economic impact on hospitals. New technology has already reduced the costs to hospitals of reporting inpatient and same-day surgery and emergency department data by an average of $1 million per year statewide since 2001. The per diem penalty provided for at N.J.A.C. 8:31B-3.3(c) for late or incomplete submissions of cost reports increased to up to $1,000 instead of $100, but it is within a hospital's control to avoid imposition of the penalty.

Federal Standards Statement

There are no Federal standards or requirements applicable to this proposed readoption with amendments. Therefore, a Federal standards analysis is not required.

Jobs Impact

The rules proposed for readoption with amendments are not expected to increase or decrease the number of jobs in New Jersey acute care hospitals or other New Jersey employers.

Agriculture Industry Impact

The rules proposed for readoption with amendments would not have an impact on the agriculture industry.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the rules proposed for readoption with amendments do not impose requirements on small businesses. The acute care general hospitals in New Jersey are the only businesses affected by the rules. Since all of these hospitals employ more than 100 full-time people, they are not considered small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

Smart Growth Impact

The Department does not anticipate that the rules proposed for readoption with amendments would have any impact on the achievement of smart growth and implementation of the State Development and Redevelopment Plan.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 8:31B.

Full text of the proposed amendments follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

CHAPTER 31B

[HOSPITAL FINANCING] HOSPITAL FINANCIAL REPORTING

8:31B-1.1 Purpose and scope

The purpose of this chapter is to satisfy the requirements of the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187; [and] P.L. 1992, c.160; P.L. 1998, c. 43, and P.L. 2004, c. 54 and c. 113, and support the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost, be available to inhabitants of the State.

8:31B-1.2 Definitions

The following words and terms, as used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

"Adjusted admissions" means inpatient admissions increased to reflect outpatient activity and is calculated by admissions multiplied by total gross revenue divided by inpatient gross revenue.

"Audited Current Cost Base" means the current cost base of the hospital, as adjusted as a result of audits conducted by the Department and/or acceptance by the Department of adjustments initiated by the hospital, in addition to the adjustments.

"Current Cost Base" means the actual costs and revenues of the hospital as identified in the Financial Elements in the reporting period, as adjusted by the Department for completeness and/or mathematical accuracy.

"Department" means the New Jersey Department of Health and Senior Services.

"Financial Elements" means those items of revenue, expenses and other data defined in N.J.A.C. 8:31B-4 for reporting to the Department of Health and Senior Services.

"Hospital" means [a] each general hospital and each specialty heart hospital that is licensed in accordance with N.J.A.C. 8:43G [or a special hospital eligible for Medicaid Disproportionate Share subsidies that is licensed in accordance with N.J.A.C. 8:43G].

"Neonate" means a newborn less than 29 days of age.

"Reporting Period" means the most recent calendar or fiscal year prior to the June 30th submission deadline for the hospital's current cost base reports.

"Reporting Year" means the year in which current financial and statistical data is being reported.

"Uniform Bill-Patient Summary" (also referred to as the UB[-82]) means a common billing and reporting form used by the hospital for each inpatient (see N.J.A.C. 8:31B-2).

8:31B-2.1 Purpose

(a) The purpose of this subchapter is to provide the basis for a single patient data reporting system to satisfy the health planning requirements of the Health Care Reform Act of 1992 (P.L. 1992, c.160). The subchapter incorporates herein by reference the most recent version of the National Uniform Bill [(UB-92,

HCFA-1450)] (UB) that has been implemented by the Department as the common hospital billing format for all payers. The data elements and design of the form have been determined by the National Uniform Billing Committee (NUBC). The NUBC includes representatives of the Federal Government, major payers and hospital associations. The NUBC is a Designated Standard Maintenance Organization (DSMO) in accordance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 as adopted by the United States Congress. The Uniform Bill may be transmitted electronically according to a format for Health Care Claim: Institutional 837, developed and maintained by another DSMO, Accredited Standards Committee X12 (ASC X12) of the American National Standards Institute (ANSI). The [UB-92] most recent version of the UB and Health Care Claim: Institutional 837 and succeeding updates are incorporated herein by reference and will be adopted once the Department has given 60 days notice that the new standard is being implemented. The [UB-92] most recent version of the UB can be obtained from the American Hospital Association, National Uniform Billing Committee, 29th Floor, 1 North Franklin, Chicago, IL 60606. The Health Care Claim: Institutional 837 can be obtained from Washington Publishing Company, 5284 Randolph Road, Rockville, MD 20852-2116.

(b) (No Change.)

8:31B-2.3 Billing form

(a) The UB[-92] is a multi-part form set. Detailed specifications are included with the UB[-92] completion guidelines.

(b) (No Change.)

8:31B-2.4 Guidelines for completion of the patient billing and abstract form

(a) Procedural guidelines for completing the patient billing and abstract form follows:

1. Guidelines for completing the billing form[, UB-92 HCFA-1450,] have been developed by the NUBC for Medicare, [Civilian Health and Medical Program of the Uniformed Services (CHAMPUS),] Medicaid, CHAMPUS/TRICARE, and Commercial Insurers.

2. – 3. (No Change.)

(b) Billing timelines requirements are as follows:

1. A UB[-92 must] shall be completed, finalized and submitted to the Data Intermediary for each patient within 30 days of discharge of the patient.

2. Where claims administration and cash flow considerations would dictate a more current billing than the 30 day requirement, a preliminary version of the UB[-92] containing only those items required for the particular payer need be utilized at the time of billing. In interim billing cases, it is required that the full patient billing and abstract information be completed and submitted to the data intermediary in compliance with the data intermediary time limits and these rules, specifically N.J.A.C. 8:31B-2.5(g). Data items reported to the data intermediary

for transmission to the Department of Health and Senior Services shall not differ from data upon which payment was based.

3. (No Change.)

8:31B-2.5 Health data submissions to the Department of Health and Senior Services

(a) A data intermediary shall be selected as follows:

1. A data intermediary is the data processor approved by the Department of Health and Senior Services responsible for collecting, editing, generating selected reports, and submitting the UB[-92] data to the Department of Health and Senior Services.

2. (No Change.)

(b) – (e) (No Change.)

(f) Reports shall be produced as follows:

1. – 3. (No Change.)

4. The ultimate responsibility for the completeness and accuracy of the UB[-92] data submitted to the Department of Health and Senior Services rests with the hospital.

5. Upon request of a payer, the final UB[-92] information shall be provided to the payer, for its own cases, by the UB[-92] Intermediary.

(g) Data shall be submitted to the Department of Health and Senior Services as follows:

1. Those data elements required to be submitted to the Department of Health and Senior Services by each hospital through the data intermediary are described in detail in the addendum to the UB[-92] guidelines. Instructions are available from the Department for formatting the UB[-92] data elements into an electronic format for reporting to the Department of Health and Senior Services using the Health Care Claim: Institutional. These instructions are known as the ANSI 837 Addendum Guide, incorporated herein by reference. The ANSI 837 Addendum Guide can be obtained from Program Manager, Health Care Financing Systems, PO Box 360, [225 East State Street,] Trenton, NJ 08625-0360.

2. – 5. (No Change.)

(h) (No Change.)

(i) The intermediary(ies) shall charge the hospitals a maximum amount of $1.45 per discharge to process hospital UB[-92] data.

8:31B-3.3 Uniform reporting: current costs and other financial data

(a) (No Change.)

(b) In addition to (a) above, hospitals shall submit, on a quarterly basis, unaudited financial and utilization data to the Department. The data shall be submitted within 60 days from the end of each calendar quarter. [The annual cost report forms for the balance sheet and statement of operation (] Data required to be submitted shall be specified by the Department but shall not exceed the data included in the B-2, L-1 and L-3 forms from the New Jersey Acute Care Hospital

Cost Report[) shall be used for the quarterly submissions]. Hospitals shall submit information [on these forms] electronically in a format compatible with Department specifications. The information shall agree with the hospital's internal unaudited financial statements. Except as otherwise provided in these rules, the information shall be consistent with Generally Accepted Accounting Principles (GAAP). The quarterly data submission specification can be obtained from the Director, Hospital Financial Reporting & Support, PO Box 360, Trenton, NJ 08625-0360.

(c) Late submission of current cost and financial and utilization data, as defined in (b) above and N.J.A.C. 8:31B-4.6(c), including Audited Financial Statements, will result in a penalty for each working day past the appropriate submission date. A [fine of $100.00 per] civil monetary penalty not to exceed $1,000 for each working day in which the hospital is not in compliance will be assessed by the Department for late submission of the Acute Care Hospital Cost Reports. A fine of $50.00 [per] for each working day in which the hospital is not in compliance will be assessed by the Department for late submission of quarterly financial and utilization data specified in (b) above. All of the specified forms, containing the required information, are necessary for a submission to be considered complete. A separate fine of $100.00 [per] for each working day in which the hospital is not in compliance will be assessed for late submission of the [Acute Care H] hospital's final audited Financial Statement[s].

8:31B-3.16 Aggregate Current Cost Data Base

(a) (No Change.)

(b) A hospital which disagrees with the Department's completeness and/or mathematical adjustments shall submit, in writing, a complete list of its exceptions to the adjustments made by the Department. This list of exceptions shall be received by the Department within 30 calendar days of the issuance of the notice of intent to close the aggregate current cost data base. If, upon review, the Commissioner determines that there were errors in the completeness and/or mathematical adjustments, a final list of adjustments will be provided to the hospital before the data is entered into the aggregate current cost data base.

(c) A hospital's current cost base submission cannot be substituted or rearranged after the aggregate current cost data base has been closed. Requests to rearrange or substitute current cost base data must be received in writing within 30 calendar days of the issuance of the notice of intent to close the aggregate current cost data base. If, upon review, the Department determines that the revised submission is acceptable, the data entered into the aggregate current cost data base will be based on the revised submission. The Department will advise the hospital of its final list of adjustments.

1. In the event that a hospital which fails to submit the most recent Acute Care Hospital Cost report due on June 30 of each year has not submitted that report prior to August 31 of the same year, the Department shall, in addition to assessing the civil monetary penalties provided for in N.J.A.C. 8:31B-3.3(c), enter zero dollars as the hospital’s total gross revenue in the Aggregate Current

Cost Data Base for the purpose of calculating the subsidies provided for in P.L. 2004, c. 113.

(d) If a hospital takes exception to the final list of adjustments provided in accordance with (b) or (c) above, it may appeal the final list of adjustments. A notice by a hospital of an intent to appeal the final list of adjustments entered by the Department into the aggregate current cost data base must be submitted in writing to the Commissioner within 15 calendar days of issuance of the final list. Within 30 calendar days of issuance of the final list of adjustments, the hospital shall submit to the Commissioner two copies of its appeal, describing in detail the basis for its challenge to the final list of adjustments. Appeals shall not include new arrangements or substitutions of current cost submission data that was not previously submitted in accordance with (b) above. The only basis to appeal a decision by the Department to default a hospital to zero for its current cost base elements is a factual challenge of the date of receipt of the hospital's Acute Care Hospital Cost Report by the Department. The appeal document shall list all factual and legal issues, including citation to applicable provisions of the hospital financing rules, and include all written documentation supporting each appeal issue. If the hospital fails to submit the required documentation within the prescribed time frame, it shall have forfeited its right of appeal and the final list of adjustments to the hospital's current cost base submission shall be deemed to have been accepted by the hospital.

1. – 3. (No Change.)

8:31B-3.24 [Off-site Primary Care

The Commissioner may establish demonstration projects involving hospital- affiliated off-site outpatient facilities providing primary care under an agreement with the Department of Health and Senior Services. For hospitals selected to participate in such programs, there may be reporting requirements, as defined in rules by the Department of Health and Senior Services, to evaluate these programs.] (Reserved)

8:31B-3.25 Net income from other sources

(a) The ne[w]t gain (loss) from Other Operating and Non Operating Revenues (as defined in N.J.A.C. 8:31B-4.61 through 4.67), and expenses of the reporting period are items considered as recoveries of or increases to the Costs Related to Patient Care (see N.J.A.C. 8:31B-4.61 through 4.67) as reported to the New Jersey State Department of Health and Senior Services.

(b) Such revenue shall include all Other Operating and Non-Operating Revenues and Expenses reported per [SHARE] NJ Acute Care Hospital Cost Report cost center costs and "expense recoveries" as Case B (see N.J.A.C. 8:31B-4.61 through 4.67), and all other items reported per the Uniform Cost Reporting Regulation as to their Case specified in N.J.A.C. 8:31B-4.61 through 4.67.

8:31B-3.26 [Update factors

(a) Economic Factor: An economic factor shall be calculated for each hospital. It shall take into account the level of hospital expenses and replacement cost of major moveable equipment, using the cost components reported to the New Jersey State Department of Health and Senior Services. The economic factor is the measure of the change in the prices of goods and services used by New Jersey hospitals. The economic factor shall be based, as far as possible, on recorded price changes. For that part of the period covered by the economic factor for which recorded prices are unavailable, the economic factor shall be based on the best available forecast of price trends.

1. The economic factor shall be determined by the Commissioner of Health and
Senior Services prior to the beginning of each year.

2. The economic factor calculation shall include the most current measure of inflation/deflation and will reflect changes in a fixed market basket of goods as determined by the Commissioner. The economic factor should not take into account changes in technology or disease entities as these are adjusted through the technology factor.

(b) Cost Change Factor: An actual cost change factor shall be calculated for each hospital, in accordance with N.J.A.C. 8:31B-4. It shall take into account the level of hospital expenses and replacement costs of major moveable equipment, using the cost components reported to the New Jersey State Department of Health and Senior Services. The actual cost change factor is the

actual measure of the change in the prices of goods and services used by New Jersey hospitals, to be based upon reported expenses.

(c) Technology Factor: The technology factor shall be based on the Scientific and Technological Advancement Allowance recommended annually to the Secretary of the United States Department of Health and Human Services by the Prospective Payment Assessment Commission (ProPAC). The factor shall be composed of the proportion of incremental operating costs associated with ProPAC's identified cost increasing technologies. Allowances for technologies not included in the technology-specific projections, less the proportion of incremental operating costs of cost-decreasing technologies identified by ProPAC will be included, if available.] (Reserved)

8:31B-3.66 [Health planning fees] Adjusted Admission Assessment

(a) A charge of $[5]10.00 per adjusted admission, as defined by the American Hospital Association, for each adjusted admission in the most recent complete calendar year shall be assessed annually on a calendar year basis for each [acute care] general hospital and each specialty heart hospital.

(b) (No Change.)

(c) In the event that a hospital, which fails to submit the most recent Acute Care Hospital Cost Report due on June 30 of each year, has not submitted that report prior to the Department's calculation of the assessment for the following year, the Department shall use the hospital's most recent assessment, increased by 15 percent, for the calculation of the following year's assessment.

8:31B-3.67 0.53 Percent Assessment

(a) Each general hospital and each specialty heart hospital shall be assessed annually on a State fiscal year basis 0.53 percent of its total operating revenue as reported in its most recent NJ Acute Care Hospital Cost Report. The amount assessed for each hospital annually shall be prorated by the Department so that the total assessed for all hospitals annually does not exceed forty million dollars. Hospitals shall pay the prorated assessed amount to the Department in twelve equal monthly installments.

1. The hospital's total operating revenue shall include revenue from any ambulatory care facility licensed to the hospital as a hospital-based off-site ambulatory care services facility.

2. In the event that a hospital, which fails to submit the most recent Acute Care Hospital Cost Report due on June 30 of each year, has not submitted that report prior to the Department's calculation of the assessment for the following year, the Department shall use the hospital's most recent assessment, increased by 15 percent, for the calculation of the following year's assessment.

(b) If a hospital subject to the 0.53 percent assessment is granted a certificate of need to close and subsequently ceases operations as a general or specialty heart hospital, the hospital's assessment shall be reduced to cover the period of time between the start of the State fiscal year and the closure of the hospital.

1. The difference between the original and reduced assessment for the closed hospital shall be reallocated proportionately among all remaining hospitals, so that the total assessment on all hospitals during the State fiscal year remains forty million dollars.

8:31B-3.76 [Necessity and appropriateness of health care services

(a) P.L.1978, c.83 provides that reasonable payment may be made only for "appropriate and necessary health care services of high quality required by (each) hospital's mix of patients." In order to discharge this statutory obligation, two systems are required: The reimbursement system, payment by the case, establishes reasonable rates for patients who are correctly assigned to a Diagnosis Related Group (DRG). A utilization review organization system is required to ensure that the hospital services which are provided are appropriate, necessary, and of high quality.

(b) This section sets forth minimum qualification criteria for utilization review organizations, prescribes the qualification procedure, and establishes a method for financing organizations which qualify. The criteria are designed to delineate the respective roles of payment and review so as to capitalize on the strengths of each. In this way, the systems may complement one another to the greatest degree, thereby promoting "effectiveness and efficiency of the health care system as a whole." L.78, c.83, Section 11C.

(c) Once designated by the Department as a qualified Utilization Review Organization, the URO shall have access to only those hospital patient records

for which it has direct review responsibility. The URO shall be required to maintain the confidentiality of the hospital and patient records. Access to this data will be allowed for the purpose of fulfilling review responsibility under these regulations.

(d) Nothing in this regulation shall be construed to supersede or conflict with any part of Title XIB of the Social Security Act (42 USC 1320c- 1320c-20) or regulations adopted thereunder, nor with prevailing statutes or contracts affecting the business of insurance.

(e) Reporting: Minimum standards for uniform reporting by the Utilization Review Organization utilizing the UB-PS data shall be determined by the Department. Format and reporting timeframe will be reviewed with the Review Organizations.

8:31B-3.77 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the text indicates otherwise.

"Active physicians" means Doctors of Medicine or Osteopathy holding unrestricted licenses and having current admissions privileges at a licensed hospital.

"Admission certification" means a review of the medical necessity and appropriateness of a patient's admission to the hospital.

"Audit Principal Diagnoses and Procedures" means to examine and validate the assignment of principal diagnoses and/or procedures by physician(s) and medical record department.

"Appropriateness of level of care" means compliance with professionally developed criteria that determine whether the patient belongs in an acute hospital, a skilled nursing facility, an intermediate care facility, or none of those.

"Binding determinations" means those decisions of a utilization review organization which direct a type or level of payment, including no payment, by the appropriate payor.

"Carve-out" means a mechanism used to identify medically unnecessary days during a patient's hospitalization which resulted from an avoidable delay. Such delays can be administrative (for example, O.R. scheduling delays) or physician related (for example, delay in responding to a consult request).

"Certification" means the process used by the Review Coordinator (R.C.) to indicate that an admission or continued stay is certified for payment purposes at given levels of care.

"Concurrent review" means a review of medical necessity and/or appropriateness conducted during a patient's hospitalization, consisting of admission and continued stay certification.

"Continued stay review" means a review and determination of the medical necessity and appropriateness of continuation of the patient's stay at a given level of care. Continued stay review may also include a detailed assessment of the quality of care being provided.

"Delegated" means authorization granted by a qualified utilization review organization to a hospital to conduct one or more review functions, subject to a

finding of the hospital's capability and willingness to accept such responsibility and submission of an acceptable plan for the review by the hospital.

1. "Full delegation" means complete delegation of both concurrent review and Quality Review Studies (QRS).

2. "Partial delegation" means authorization by the URO to a hospital to conduct a portion of the review. The remainder of review is provided by staff of the URO.

3. "Non-delegation" means the URO retains responsibility to perform all of the review activities in a hospital.

"Denial" means a formal decision by a URO or a delegated hospital committee that all or part of a patient's stay is medically unnecessary and/or inappropriate, with consultation by physicians licensed to practice medicine in New Jersey (See Physician Advisor--Item Y).

"Denied days" means days which have been determined to be medically unnecessary.

"Diagnosis Related Groups (DRGs)" means a patient classification scheme in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications. Each DRG exhibits a consistent amount of resource consumption as measured by some unit (e.g., length of stay, dollars, etc.).

"Discharge planning" means advance preparations for placement of a patient at another level of care in the appropriate setting after hospital discharge.

"Focused review" means an application of sampling techniques such as an intensification of or an exemption from detailed review of certain groups of patients or common diagnoses where data indicate it is reasonable to do so.

1. Focus-in describes an intensified review of a specified category of patients, diagnoses, procedures, and/or physicians.

2. Focus-out describes specific categories of patients, diagnoses, procedures, and/or physicians who are exempt from concurrent review, diagnosis, procedures, and/or physicians.

"Grace days" means medically unnecessary or inappropriate days of hospitalization which payor may reimburse in order to facilitate administrative processes or to insure that the implementation of binding determinations does not have a punitive effect on patients or institutions.

"Inliers" means inpatient cases assigned to DRGs, as identified in N.J.A.C. 8:31B-5.3(c) having lengths of stay within the high and low trim points.

"Intensity of service" means the level of service that a patient receives in a hospital setting.

"Intermediate Care Facility (ICF)" means an institution which provides continuous or Intermittent nursing care to in-patients under the general direction of a professional registered nurse.

"Length of Stay" means the number of days that a patient is hospitalized.

1. "Certified length of stay" means the number of days which have been determined to be medically necessary at covered levels of care for payment purposes.

"Medical necessity" means compliance with professionally developed criteria and standards of care for determining that a patient warrants an acute hospital level of care for a given diagnosis and/or problem.

"Outliers" means patients who display atypical characteristics relative to other patients in a DRG (see N.J.A.C. 8:31B-3.38(c)2).

"Peer review organization" means an organization which is composed of or governed by active physicians, and other professionals where appropriate, who are representative of the active physicians in the area in which the review mechanism operates, which is organized in a manner that insures professional competence in the review of services.

"Physician Advisor (P.A.)" means a currently licensed physician who makes determinations and provides consultation on a referral basis to nonphysician reviewers in cooperation with the Attending Physician on the appropriateness, quality and/or necessity of an individual's admission to or continued stay in a hospital.

"Preadmission certification" means a form of health care review which occurs prior to a patient's admission to a hospital and consists of a determination of the medical necessity and appropriateness of a patient's elective admission to a hospital level of care.

"Profile" means a presentation of aggregated data in formats which displays patterns of health care services over a defined period of time.

"Quality assessment" means a retrospective medical record review program by the physician advisor to assess the quality of services rendered.

"Quality review study" means a retrospective, medical record review of the quality and/or utilization of health care services.

"Reconsideration" means a process which allows a patient, patient representative, or physician to request the URO to hold a formal hearing to reconsider an adverse determination.

"Review Coordinator (RC)" means a health care professional, usually a Registered Nurse, who assists physicians in performing chart review to determine if a hospital stay is medically necessary and if the services provided are appropriate.

"Retrospective review" means Medical Record Review performed after a patient has been discharged.

"Severity of illness" means the manifestation of disease or injury that clinically indicates the need for hospitalization.

"Utilization review plan" means a description of utilization review activities to be prepared by the URO and approved by DOH. The plan shall describe methodology for determining hospital delegated status; the criteria and description of the methodology for monitoring admission and discharge review; the criteria and description of the methodology to review the performance of delegated and nondelegated review and focus program.

"Principal diagnosis" means that condition established after study as being responsible for occasioning the admission of the patient to the hospital for care.

"Principal procedure" means that procedure most related to the principal diagnosis and performed for definitive treatment rather than one performed for

diagnostic or exploratory purposes, or was necessary to take care of a complication:

1. If only one procedure was performed, it is the principal;

2. If more than one procedure was performed, the principal procedure is one which was performed for definite treatment, rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication;

3. If more than one procedure was performed for definite treatment, the principal procedure is that most related to the principal diagnosis.

"Skilled Nursing Facility (SNF)" means an institution which is primarily engaged in providing skilled nursing care and related services for inpatients who require medical supervision of their care or rehabilitation services on a daily basis.

"Trim points" means high and low length of stay cutoff points assigned to each DRG (see N.J.A.C. 8:31B-5.3). Cases falling outside trim points are classified as outliers.

"Utilization Review Organization (URO)" means a group of physicians within a designated geographical area who review the health care provided to patients in area hospitals. Physicians may be assisted by other health care professionals.

"Utilization review plan" means a description of utilization review activities to be prepared by the URO and approved by DOH. The plan shall describe methodology for determining hospital delegated status; the criteria and

description of the methodology review; the criteria and description of the methodology to review the performance of delegated and nondelegated review and focus program.

8:31B-3.78 Criteria for qualification

(a) Applicability: Each inpatient in each hospital selected by the Commissioner pursuant to P.L. 1978, c.83, Section 5b, must be subject to review by a qualified utilization review organization concerning the necessity and appropriateness of inpatient admission and continuing stay. The minimum set of activities required to so qualify are set forth below:

1. All cases: With respect to all cases, a qualifying utilization organization:

i. Shall certify the medical necessity of each admission;

ii. Shall certify the appropriateness of the level of care to be provided;

iii. May, with the approval of the Department, discharge the obligations of (a)i and ii above through an appropriate review system;

iv. Shall, with the advice and consent of the Department, institute such systems, which may include, but not be limited to, concurrent, retrospective and focused review, medical care evaluation studies and profile analyses, which best promote efficiency and effectiveness with respect to the health care delivery system, taken as a whole; provided, however, that nothing herein shall be

construed as to involve the Department in supervising or regulating the private practice of medicine;

v. Pursuant to N.J.A.C. 8:31B-3.17(b), the Department having given adequate notice to the hospital, may perform a cursory or detailed on site review at the Department's discretion of any hospital procedure deemed necessary to determine the effectiveness of the reimbursement system in effect.

vi. Shall consult with the Department which shall set common upper and lower trim points with respect to all patients; however, any modification of trim points by the Department during a rate period shall not effect the revenues to which any hospitals are entitled under determinations of the Commission. Adjustments to hospital's revenue to compensate for changes in trim points shall be accomplished at final reconciliation, and interim adjustments may be effected through adjustments to hospitals' Indirect Cost percentages, subject to Commission approval, as provided for in N.J.A.C. 8:31B-3.51 through 3.62;

vii. Shall provide for an appropriate mechanism by which to hear and adjudicate appeals by patients, payers, physicians, or the hospital concerning the determinations made pursuant to this subchapter. With respect to such review, the standards to be applied shall be consistent with the prevailing patterns of medical practice in the area or state, as appropriate;

viii. Shall further provide, through the same mechanism, for appeals by individual patients in exceptional cases of DRG assignments which, although technically correct, may produce grossly inequitable or excessive payments. To initiate an appeal, a letter of request from the patient shall be considered as authorization for the Department to review and assess any necessary information pertinent to the hospitalization or charges in question. Upon demonstration, by substantial evidence, that application of the DRG system would result in inequitable consequences for the patient, the qualified utilization review organization may direct that payment be based on an alternative to the DRG rate (for example, charges);

ix. Shall provide a second level of appeal. Party not satisfied with the decision on the first level appeal, may request an appeal to the second level through the appropriate Utilization Review Organization;

x. Shall insure that all binding determinations of medical necessity or appropriateness are made by qualified review personnel of an established peer review mechanism representative of physicians in the appropriate area of the State, as defined in N.J.A.C. 8:31B-3.77;

xi. Shall render a decision in any appeal within 30 working days from the date of receipt of the appeal by the qualified Utilization Review Organization (URO). The appellant, or his or her insuror,

shall not be liable for payment to the hospital until a decision on the appeal has been made and communicated to the parties affected. A qualified URO shall not be deemed in receipt of an appeal if the hospital involved is more than one month delinquent in payment of the Commission approved rate to be paid to the URO by the hospital. Any amount not paid to the hospital because of its delinquency in payment to the URO, and the failure to hear an appeal shall not be recoverable by the hospital through bad debt or charity write-offs, but shall become a loss of revenue to the hospital.

(1) DRG Patient Appeal requests shall be submitted to the Department of Health and Senior Services for review within one year after issuance of the bill by the hospital. Any requests submitted thereafter will not be processed for appeal.

xii. Shall certify the necessity and appropriateness of the services, days, and where it is judged reasonable to do so, the items charged to such patients by the hospital;

xiii. Shall institute such system of concurrent review as may be necessary in order to assure the timely discharge, or placement to the most efficient, appropriate level of care, consistent with high quality; and

xiv. Shall, using a reasonable sampling technique, audit principal diagnosis and principal procedure, in order to assure that typical cases have been assigned to appropriate diagnosis related groups.

8:31B-3.79 Use of findings

(a) Findings shall be used in all cases as follows:

1. Denial of Payment: Unnecessary admissions: The qualifying utilization review organization shall direct the appropriate payor to deny payment concerning any admission for which medical necessity has not been certified; provided, however, that a payor may agree with any hospital to reimburse charges for a grace period, not to exceed three calendar days, after notification to the patient, hospital, physician, and payor, of denial of payment certification.

2. Adjustment of Payment shall be made as follows:

i. Continuing necessity: The qualifying utilization review organization shall prospectively direct the appropriate payor to deny charges for such items, services or days for which continuing medical necessity has not been certified; provided, however, that a payor may agree to reimburse any hospital for a grace period, not to exceed three calendar days, after notification of the patient, physician, payor and hospital of the denial of medical necessity for continuing stay.

ii. The following shall apply to a finding of an inappropriate level of care: Should the qualifying utilization review organization determine

that, for a portion of the patient's length of stay, the level of care is appropriate to a skilled nursing facility and/or intermediate care facility level-of-care, and that a hospital has documented a good faith continuing effort to obtain placement of the patient to the appropriate level-of-care, a Skilled Nursing Facility (SNF) and/or Intermediate Care Facility (ICF) rate, calculated as follows, will become the basis for determination of reasonable Direct Patient Care Costs for that portion of the stay in an atypical case.

(1) Reimbursement for each eligible patient will be based upon a Statewide weighted average SNF or ICF per diem rate of Medicaid participating long- term care facilities, in effect as of January 1 of the rate year. Separate Statewide weighted average per diem rates will be calculated for both the Skilled (SNF) and Intermediate (ICF) levels of care patients as follows:

(2) Multiply the SNF payment rate, of each Medicaid long-term care facility, in effect as of January 1 of the rate year by the total Medicaid SNF patient days as reported on the most recent Medicaid cost report (12- month period). The Statewide Medicaid total SNF dollars are divided by the total Statewide Medicaid SNF days to arrive at a weighted average SNF per diem. The ICF per diem is calculated following the same steps using total Medicaid ICF days and

costs. These SNF and ICF rates will be final for billing purposes and final reconciliation.

iii. The following shall apply to a finding of misassigned DRGs: The qualifying utilization review organization shall direct the hospital and the Uniform Bill Intermediary to make an appropriate adjustment to the price per case where the DRG to which the patient is correctly assigned differs from the DRG on which payment was based. Similarly, the qualifying utilization review organization shall direct the hospital and the Uniform Bill Intermediary to classify cases as outpatients, to be billed as outpatients when there is a finding of medical necessity for items and services rendered, but no medical necessity for inpatient admission.

3. The following shall apply to apportionment of liability: Upon a prospective finding that certain days, services, or items will not be necessary, the qualifying review organization shall so advise the respective patient, attending physician, hospital, and payer. Once all involved parties have had due notice and have exhausted all appeals, under N.J.A.C. 8:31B-3.78(a)1vii, the utilization review organization may direct the hospital to assign financial liability for such unnecessary days, services, or items to the patient. Accordingly, except for any grace days which a payer may agree to reimburse pursuant to this section (N.J.A.C. 8:31B-3.79), liability for the appropriate price per case shall be fixed at the point in time at which the patient was eligible for discharge; and any further days or services shall, subject to prevailing contracts and statutes, be the sole

liability of the patient to be reimbursed to the hospital at a rate, determined by the hospital, no greater than its charges for such days or services established in accordance with N.J.A.C. 8:31B-3.53 through 3.57. Revenues received by the hospital in accordance with this provision shall be treated as Expense Recoveries in accordance with N.J.A.C. 8:31B-4.62 through 4.67.

4. Reporting shall be accomplished as follows: The qualifying utilization review organization shall report all denials and adjustments to the hospital, the appropriate physician, and the payer in a timely manner. All denials and adjustments shall be compiled by diagnosis related group and by hospital, and reported to both the Commission and the Department on, at least, an annual basis. However, except for adjustments made in accordance with N.J.A.C. 8:31B-3.71 through 3.86, any adjustment in a hospital's budget, or in a standard for a Diagnosis Related Group or set of Diagnosis Related Groups shall be made only by the Commission, upon recommendation by the Commissioner through a change in the rate period or schedule of Rates, approved by the Health Care Administration Board (see N.J.A.C. 8:31B-3.87).

8:31B-3.80 Qualification procedure

(a) Submission of plans:

1. Any payor, Professional Standards Review Organization, or other qualified entity may submit to the Commissioner, a plan reasonably designed to meet the criteria set forth in N.J.A.C. 8:31B-3.78.

2. A plan may be designed to cover all patients to be admitted by a hospital or group of hospitals, or an appropriate portion thereof, and, where appropriate, on a hospital specific basis, may provide for a form of delegated review in which the hospital performs certain review functions, with monitoring and oversight by the qualifying utilization review organization. Each plan shall be designed to meet the criteria set forth in N.J.A.C. 8:31B-3.78 in the most efficient manner and shall include a payment proposal.

i. Each plan shall contain a review protocol, a description of how review criteria are to be determined and employed, and a plan for focusing reviews;

ii. Each plan which includes provision for delegated reviews shall include a description of how the performance of review at delegated hospitals will be monitored, and of the procedures for awarding and suspending delegation;

iii. The payment proposal shall, at a minimum, itemize proposed cost by category of direct review costs, overhead costs, monitoring costs, physician compensation, and other.

(b) Department review and recommendation:

1. The Department shall review all such plans within 90 days of submission and certify those plans which, consistent with L. 78, c.83:

i. Can be reasonably expected to fully meet the criteria set forth in N.J.A.C. 8:31B-3.78;

ii. Are designed to provide the services required above in the most efficient manner; and

iii. Consistent with high quality medical care, can be expected to best promote effectiveness and efficiency with respect to the health care delivery system, taken as a whole.

2. Special consideration shall be given to organizations which submit joint plans providing for coverage of wide geographical areas. In order to promote effectiveness and efficiency with respect to the health care system, the Department shall seek to avoid the undue proliferation of plans. Where appropriate, the Department may approve more than one plan for a given hospital or region; however, it shall approve more than two plans for a given hospital only under extraordinary circumstances. In considering plans for certification, the Department shall give consideration to the views of hospitals in the areas involved.

3. The Department may approve an effective date for plan activity no later than 90 days after approval of a plan.

8:31B-3.81 Payment for utilization review services

(a) Proposal: The Commissioner shall propose to the Commission reasonable adjustments to the Schedule of Rates for all hospitals to which this subchapter is applicable, together with such terms and conditions as may promote efficiency and effectiveness with respect to the health care delivery system, taken as a whole. Consistent with the criteria set forth in N.J.A.C. 8:31B-

3.78, such proposal, which shall be based on the Department's review, analysis, and findings as to the reasonableness of cost proposals under N.J.A.C. 8:31B-3.71 through 3.86 shall be broken into the components defined in N.J.A.C. 8:31B-3.71 through 3.86.

(b) Commission approval: Following a hearing pursuant to N.J.A.C. 8:31B-3.78, the Commission shall approve or modify, and direct an appropriate adjustment to the Schedule of Rates to which this provision applies. In accordance with N.J.A.C. 8:31B-3.87(a)3, each affected hospital shall implement the approved adjustment consistent with the payor selection procedure set forth in (c) below.

(c) Payor selection procedure:

1. Within 30 days of approval by the Commissioner of any plan in accordance with N.J.A.C. 8:31B-3.80 any payor may:

i. Subject to approval according to N.J.A.C. 8:31B-3.80, apply its own qualified utilization review organization and receive a full discount from the adjustment approved pursuant to N.J.A.C. 8:31B-3.81(b);

ii. Contract directly with a qualified utilization review organization and receive a full discount from the adjustment approved pursuant to N.J.A.C. 8:31B-3.81(b);

iii. Where delegated review has been approved, contract directly with the qualifying utilization review organization to monitor and assist delegated review conducted by hospitals, and receive an

appropriate discount from the overhead and monitoring cost components of the adjustment approved pursuant to N.J.A.C. 8:31B-3.81(b); or

iv. Whenever a payor fails to select (c)1i, ii or iii above, it shall be deemed to have elected (c)1ii or iii above, whichever is appropriate, with the qualified utilization review organization responsible for reviewing the greatest proportion of cases in the hospital involved. In the case of (c)1iii above, the payor shall pay the full utilization review adjustment to the hospital, which shall be responsible for remitting the appropriate amount to the qualified utilization review organization on a timely basis.

2. Payors must notify the Department, hospitals, and all qualified utilization review organizations, of their election under (c)1 above in writing. They may change their elections at any time subject to 60 days written notice.

3. Any payor with total utilization among its subscribers or beneficiaries of fewer than 500 days per 1,000 enrollees in the prior calendar year may apply to the Commission for a full discount from the adjustment without exercising (c)1i, ii or iii above, or being subject to (c)1iv above.

8:31B-3.82 Performance standards for maintenance of qualification

Within one year after certification, and each subsequent year thereafter, each qualified utilization review organization shall submit, in a form and manner to be prescribed by the Commissioner, such information and data as may be

required to adequately assess the performance of such organizations in accordance with N.J.A.C. 8:31B-3.78. Qualification may be terminated on a finding of inadequate performance.] through 8:31B-3.82 (Reserved)

8:31B-4.1 Purpose

(a) The purpose of this subchapter is to provide the basis for a standardized system of reporting the financial elements to be used in conjunction with the Hospital Reporting of Uniform Bill-Patient Summaries regulation (N.J.A.C. 8:31B-2)[,] and the Financial Reporting and Monitoring regulation (N.J.A.C. 8:31B- 3) [and the Uniform Cost Reporting rule (N.J.A.C. 8:31A-5.5)] for implementing the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187; P.L. 1992, c.160, P.L. 1998, c. 43, P.L. 2004, c. 54, and P.L. 2004, c. 113.

(b) (No Change.)

PART I. REPORTING PRINCIPLES AND CONCEPTS

8:31B-4.6 Reporting period

(a) The basic reporting period is 12 consecutive calendar months, which may be either on a calendar or fiscal year basis at the hospital's option. Hospitals shall provide the Department six months notice of an intent to change the reporting period before implementing any revised reporting period or the Department will use the hospital's most recent, previously closed cost report for

the purposes listed in N.J.A.C. 8:31B-4.1(b) adjusting the data as provided for in N.J.A.C. 8:31B-3.16, 3.66, and 3.67, as applicable.

(b) (No Change.)

(c) Each hospital's [Current Cost Base] Acute Care Hospital Cost Report submission for the most recent reporting period is due on [the following] June 30 of the following calendar year. Each hospital's most recent Annual Audited Financial Statement is due on [the following] June 30 of the following calendar year. Failure to meet these time frames will result in penalties as stated in N.J.A.C. 8:31B-3.3.

8:31B-4.14 Matching of revenues and expenses

(a) – (e) (No Change.)

(f) Revenues are classified as either operating or non-operating according to the following definitions:

1. – 2. (No Change.)

i. – ii. (No Change.)

iii. Interfund transactions (see N.J.A.C. 8:31B-4.16(c)[7]).

8:31B-4.15 Revenues and deductions from revenue

(a) If a hospital receives less than its full charges for the services it renders, it shall report to the Department both the gross revenue and revenue "adjustments" resulting from failure to collect full charges for services provided. These revenue adjustments are called Deductions from Gross Revenue. The

specific deductions required for reporting Revenue Related to Patient Care, as defined in N.J.A.C. 8:31B-4.32 are defined in (a)1 through 11 below. Any individual allowance must be reported in only one of the 10 deduction categories and three contra categories (although individual transactions may be distributed among several if appropriate):

1. -7. (No Change.)

8. Charity care: These deductions represent charges for patients determined to be eligible for charity care pursuant to N.J.A.C. 8:31B-4.3[7]8.

9. – 11. (No Change.)

(b) (No Change.)

8:31B-4.21 Accounting for capital facilities cost

(a) – (f) (No Change.)

(g) Debt service requirements are principal and interest on buildings, fixed equipment, land, land improvements, leasehold improvements, and capitalized renovations as well as escrow payments in addition to principal and interest required under the terms of a mortgage but not including operating expenses as defined by GAAP and lease payments required for leased assets capitalized in accordance with the GAAP.

1. – 3. (No Change.)

4. Capitalization Policy:

i. – ii. (No Change.)

iii. This shall be the required Capitalization Policy for the reporting of assets acquired (and renovations per (g)6 below), subsequent to a hospital's first Commission approved Schedule of Rates. Assets acquired prior to this date are to be reported in accordance with GAAP.

5. (No Change.)

6. Depreciation Policies:

i. (No Change.)

ii. The estimated useful life of a depreciable asset is its normal operating or service life in terms of utility to the hospital. Some factors to be considered in determining useful life include normal wear and tear, obsolescence due to reasonably expected technological advances, climatic or local conditions and the hospital's policy of repair and replacement. In selecting a proper useful life for computing depreciation, hospitals must utilize Asset Depreciation Range or the most recent approved [or] American Hospital Association useful life guidelines at the time of the cost filing [(i.e., 1978 Revisions)]. Costs of alterations, renovations, etc. over $300.00 which extend the life of an asset at least three years are to be added to the remaining book value of the altered or renovated asset and depreciated straight-line over the remaining useful life of the asset (as defined in N.J.A.C. 8:31B-4.3).

iii.-v. (No Change.)

7. - 9. (No Change.)

(h) (No Change.)

8:31B-4.23 Reporting of pledges

All pledges, less a provision for amounts estimated to be uncollectable, are to be included in the hospital's financial reports. If unrestricted they are to be reported as non-operating revenue in the Unrestricted Fund in the period the pledge is made. If part of the pledge is to be applied during some future period, that part is to be reported in the period the pledge is received as deferred revenue. If restricted, they are to be reported as an addition to the appropriate restricted fund balance. See AICPA, Hospital Audit Guide[. [FN1]] available at www.AICPA.org, American Institute of Certified Public Accountants, 1211 Avenue of the Americas, New York, NY 10036.

[[FN1] American Institute of Certified Public Accountants, 1211 Avenue of the Americas, New York, NY 10036.]

8:31B-4.25 Related organizations

(a) Auxiliaries, guilds, fund raising groups and other related organizations frequently assist hospitals. In addition, hospitals frequently use self-insurance trusts and captives to manage their insurance obligations. Such organizations are independent if they are so characterized by their own charter, by-laws, tax-exempt status and governing board or a sufficient combination of these

characteristics to demonstrate their independent existence from the hospital. The financial reporting of these organizations should be separate from or combined with reports of the hospitals in accordance with the AICPA's Hospital Audit Guide, as amended and supplemented, available from the AICPA Order Department, [P.O. Box 2209, Jersey City, N.J. 07303] 1211 Avenue of the Americas, New York, NY 10036 or at www.AICPA.org.

(b) – (d) (No Change.)

(e) For self-insurance trusts and captives, hospitals must indicate that they have complied with the reporting requirements of the New Jersey Health Care Facilities Financing Authority, where applicable.

PART II. [FINANCIAL ELEMENTS] GENERAL GUIDANCE

8:31B-4.35 Educational, research and training program

(a) (No Change.)

(b) Research program costs are those costs incurred by a hospital in systematic, intensive study directed toward a better scientific knowledge of the provision of health care services in a program of the National Institutes of Health or other program [approved by the Commission]. Specific purpose grants or other funds received to offset the costs of such programs from the Federal government, New Jersey State government, New Jersey Heart Association, or other governmental or charitable organizations sponsoring such programs are

applied to offset Costs Related to Patient Care per N.J.A.C. 8:31B-4[, Part IV] of this manual.

(c) (No Change.)

8:31B-4.38 Charity care and reduced charge charity care

(a) Charity care includes only the reasonable cost of the following:

1. Charity care for services, provided the patient is qualified as eligible pursuant to N.J.A.C. 10:52-1[0]1;

2. Advanced life support (ALS) services provided pursuant to P.L. 1984, c.146 (N.J.S.A. 26:2K-7 et seq.), provided the patient is qualified as eligible for charity care pursuant to N.J.A.C. 10:52-1[0]1;

3. Charity care as defined by following N.J.A.C. 10:52-1[0]**1** for outpatient dialysis services provided after September 1, 1987 to patients ineligible for Medicare coverage. [Reasonable costs shall be limited to the lower of the established Medicaid rate or the prospectively determined composite rate as established by Medicare.] The amount reported by the hospital as charity care shall not include Medicare co-insurance amounts, since Medicare will reimburse providers for the amount, provided the patient is eligible for charity care pursuant to N.J.A.C. 10:52-1[0]1.

(b) (No Change.)

8:31B-4.40 Demographic information

[(a) Hospitals which are licensed to provide acute care services shall submit information about all inpatients and all outpatients to the Department of Health and Senior Services.

1. These hospitals shall submit quarterly information to the Department of Health and Senior Services for all patients who have balances which were written off to bad debt (in that quarter) and for all patients who were screened for charity care (in that quarter). This information shall be provided on media specified by the Department.

i. Quarterly periods shall be: January 1 through March 31; April 1 through June 30; July 1 through September 30; and October 1 through December 31. The first quarter will be from January 1, 1993 through March 31, 1993.

ii. Information will be reported about each patient described in (a)1 above. This information will include: age; sex; marital status; health insurance coverage; health insurance coverage of the parent, spouse or responsible party (when the patient does not have insurance); hospital code number; county in which the hospital is located; employment status code; total charges; amount written off; reason for patient's failure to pay; DRG code (for inpatients); CPT-4 code (for outpatients); family income amount; family size; family assets amount; patient account number; Zip Code; financial screening status; subsidy approval percent; medical record number; treatment date; and treatment location.]

The statutory requirement for the Department to collect demographic information specified in N.J.S.A. 26:2H-18.59c. is met through hospitals' submission to the Department's fiscal agent of charity care claims, which contain age, sex, and type of health insurance coverage, if any. Information on marital and employment status from any available source could be collected.

8:31B-4.42 [Capital facilities [FN1]

(a) Buildings and Fixed Equipment:

1. The costs of Capital Facilities used for Services Related to Patient Care as defined in N.J.A.C. 8:31B-4.21, except for Major Moveable Equipment as defined in 8:31B-4.21 and 4.44, are included as financial elements for all hospitals through a Capital Facilities Allowance calculated in accordance with N.J.A.C. 8:31B-3.27(a)1i through vii.

2. The amount of Revenue Related to Patient Care prospectively included for Capital Facilities in a hospital's Preliminary Cost Base and Schedule of Rates is to be funded, in the form of cash and/or investments, in the Internally Generated Plant Replacement and Renovation Fund (Plant Fund). Use of the Plant Fund, including any income (net of income taxes) generated by the fund, is restricted to the payment of Capital Cash Requirements and renovations and down payment on replacement of buildings, building components, and fixed equipment where Certificate of Need approval has been granted. [FN1] For those hospitals which, as part of a debt service agreement relating to Capital Facilities, are or will be

required to establish and fund a Restricted Debt Service Reserve Fund, all the revenue included for Capital Facilities in those hospital's Schedule of Rates must be placed in the Reserve Fund as it is received. Once the Reserve Fund is fully funded, it must remain so for the period of time specified in the debt service agreement. Only after the Reserve Fund has been fully funded can the hospital utilize Capital Facilities revenue for other approved purposes.

3. The hospital's governing board, subject to the Certificate of Need process, may use the Plant Fund for appropriate needs of the hospital's service area including the development of multi-institutional programs, the merging of the hospital with other institutions, the provisions of service in alternate modes or settings, or the reduction or elimination of services in an orderly manner including employee relocation, provision for pension rights, and other costs associated with ceasing operation.

[FN1] For Profit Hospitals who may be subject to taxes on interest income generated on the Plant Fund or any portion of the Plant Fund tax officials deem to be taxable income, may properly pay such taxes from the Plant Fund. After completion of final reconciliation (see N.J.A.C. 8:31B-3.71-3.87) and upon receipt by the Department of adequate documentation that such payments have been made, they shall be added to the Capital Facilities Formula Allowance indirect portion of the next year's Schedule of Rates. For Profit Hospitals shall not be required to fund depreciation payments for Capital Facilities.] (Reserved)

8:31B-4.44 [Major Moveable Equipment [FN1]

Major Moveable Equipment, as defined in 8:31B-4.21 includes straightline depreciation costs on owned or capitalized leased Major Moveable Equipment plus a Price Level Depreciation Allowance in excess of this historical depreciation (see 8:31B-3.27(a)2 for the explanation of how this allowance is calculated) and operating lease/rent payments relative to Major Moveable Equipment utilized for Services Related to Patient Care. Leased Major Moveable Equipment is to be capitalized or reported as operating lease costs in accordance with Generally Accepted Accounting Principals. [FN2] Major Moveable Equipment Costs so determined are reported as a Natural Classification of Expense (see 8:31B-4, Part III, below) of each cost center. Major Moveable Equipment utilized by more than one functional cost center must be assigned to the using cost centers based on an estimate of each center's utilization. Capitalized repair and installation costs should be included with the cost of the equipment. (See also 8:31B-4.32.) Interest associated with capitalized financing purchases or leases is to be excluded and reported as a reconciliation, per 8:31B-4.66(e), since the Internally Generated Major Moveable Equipment Replacement Fund is established to provide sufficient funds to replace purchased equipment or meet installment payments for financed equipment (both principal and interest).

[FN1] For-Profit hospitals shall be reimbursed for major moveable equipment through straightline depreciation, and interest as reported in accordance with Section I.

[FN2] See Financial Accounting Standards Board Statement of Financial Accounting Standards Numbers 13, 17, and 23.] (Reserved)

8:31B-4.46 [Reasonable Working Capital

(a) Working Capital, the difference between current assets and current liabilities, is included as a financial element through:

1. Provision for an initial infusion of working capital for those hospitals lacking a reasonable working capital position as of the date of issuance of their initial Commission approval Schedule of Rates; and

2. An ongoing working capital provision for all hospitals, i.e., working cash increases. (For this purpose, the current portion of long term debt payments is not to be included in current liabilities because this financial element is treated separately.)

(b) In the absence of unusual circumstances, if all patients paid for service when rendered, there would be no net working capital requirements to be derived from Revenues Related to Patient Care. Therefore, Working Capital increases are tied to delays in payments after services are rendered.

(c) Accordingly, achieving equity among payors requires that this financial element be included in payments in relation to the duration of time between the

rendering of services and the receipt of payment. The cost to the payor should also have a reasonable relationship to the cost of money, i.e., to interest rates that hospitals could reasonably be expected to pay for working capital loans, where the interest income is taxable to the lender.

(d) Subject to change with significant changes in interest rates (that is, so long as interest rates are between six percent and 20 percent per annum), the cost of working capital required is defined as one percentage of patient services billings per month for the approximate period of time between the final billing services and the payment therefore. To encourage prompt timely payments and to minimize potential late payment "penalties," Hospitals' Schedule of Rates shall include a provision for working capital requirements of five percent of Gross Revenue Related to Patient Care in addition to all other approved financial elements subject to the determination by the Commission of quantifiable economic benefits for prompt payment by payers.] (Reserved)

8:31B-4.47 [Return on investment

(a) Because of all of the costs for which non-profit hospitals require a return on investment are provided elsewhere under allowable financial elements (e.g., working capital, replacement costs in excess of historical costs, i.e., Major Moveable Equipment Price Level Allowance and Capital Facilities Formula Allowance) it is not included as a distinct Financial Element.

(b) However, because the Major Moveable Equipment Price Level Allowance is not available to for-profit hospitals and because for-profit hospitals

have obligations that non-profit hospitals do not, e.g., income taxes and stockholder returns, for-profit hospitals shall receive, as a distinct Financial Element, a return on investment calculated in the manner described in N.J.A.C. 8:31B-3.29(b).] (Reserved)

[PART III. NATURAL CLASSIFICATIONS OF EXPENSE]

8:31B-4.51 Salaries and Wages

Salaries and Wages are [renumeration] remuneration, including stipends, payable in cash, for services performed by an employee for a hospital, except a physician, including compensation for time not worked such as on call, vacation, holiday and sickpay; or the monetary value assigned to direct services provided to the hospital by a person performing in an employee relationship. Salaries and wages are reported per N.J.A.C. 8:31B-4.131. Monetary value is not to be assigned to the services of students or other volunteer workers. All labor costs (including deferred income which qualifies as pension costs) shall be included in the accounting period during which the employee accrues the remuneration for their services.

8:31B-4.52 Physician Compensation--Hospital Component

That portion of compensation for a physician's (M.D., D.O., D.D.S., D.M.D./M.D.) activities, provided through agreement with a hospital, representing services which are not directly related to an identifiable part of the medical care

of an individual patient is the hospital component of physician compensation, and must be split between salaries and fees per N.J.A.C. 8:31B-4.131. Hospital services include teaching, research conducted in conjunction with and as part of patient care (to the extent that such costs are not met by special research funds), administration, general supervision of technical personnel, laboratory quality control activities, committee work, performance of autopsies, and attending conferences as part of the physicians' hospital service activities. The allocation of physician compensation between hospital and professional components and documentation thereof is to be in accordance with Medicare [HIM- 15, Section 2108] manuals at www.CMS.hhs.gov/manuals for provider component.

8:31B-4.53 Physician Compensation--Professional Component

That portion of compensation for a physician's services provided through agreement with a hospital pertaining to activities which are directly related to the medical care of an individual patient is the professional component of physician compensation, (i.e., remuneration for the identifiable medical services by the physician which contribute to the diagnosis of the patient's condition or to his treatment) and must be split between salaries and fees per N.J.A.C. 8:31B-4.131. The allocation of physician compensation between hospital and professional components and documentation thereof is to be in accordance with Medicare [HIM-15, Section 2108] manuals at www.CMS.hhs.gov/manuals.

8:31B-4.55 Medical and Surgical Supplies

(a) Medical and Surgical Supplies are medically necessary supplies, appliances, and minor moveable equipment (as defined in N.J.A.C. 8:31B-4.20) furnished by and used at a hospital for the care and treatment of a patient during a patient's episode of hospital care, and reported per N.J.A.C. 8:31B-4.131. Medically necessary supplies exclude all supplies furnished by a hospital but used by a patient after his episode of care except those items where it would be medically unreasonable to limit the patient's use of the item to his episode of hospital care. (See N.J.A.C. 8:31B-4.20 for the reporting of minor moveable equipment.) Take home supplies for rental Dialysis and Home Health Care should be included to the extent set forth in Medicare [HIM-29 and HIM-11 respectively] manuals at www.CMS.hhs.gov/manuals. The fair market value of donated Medical and Surgical Supplies is assigned to this classification if the commodity would otherwise be purchased by the hospital.

(b) – (e) (No Change.)

8:31B-4.59 Major Moveable Equipment

Major Moveable Equipment, as defined in N.J.A.C. 8:31B-4.21 are expenses to be included in the costs of each center at historical depreciation costs (for both owned and capitalized leased equipment) and operating lease expenses. Interest expense incurred through purchase or capitalized leases of Major Moveable Equipment is not included with Major Moveable Equipment costs [and is reported per N.J.A.C. 8:31B-4.66(e)].

Leased Major Moveable Equipment is to be capitalized or reported as operating lease costs in accordance with Generally Accepted Accounting Principals. [FN2] Major Moveable Equipment utilized by more than one functional cost center must be assigned to the using cost centers based on an estimate of each center's utilization. Capitalized repair and installation costs should be included with the cost of the equipment. (See also 8:31B-4.32.) Interest associated with capitalized financing purchases or leases is to be excluded and reported as a reconciliation, since the Internally Generated Major Moveable Equipment Replacement Fund is established to provide sufficient funds to replace purchased equipment or meet installment payments for financed equipment (both principal and interest).

[PART IV. RECONCILIATION OF COSTS AND REVENUES RELATED TO PATIENT CARE WITH HOSPITAL UNRESTRICTED FUND EXPENSES AND REVENUES]

8:31B-4.61 Reports of costs and revenues

(a) (No Change.)

(b) Items of other operating expense and revenue are excluded from Services Related to Patient Care reporting centers through reporting in N.J.A.C. 8:31B-4.131. Other operating expenses and revenues so determined, in addition to non-operating revenues, are to be classified in N.J.[S.A.] A.C. 8:31B-4.131, to account for all revenue and expense transactions of the hospital's Unrestricted

Fund per the hospital's financial statements. Accounting differences between the hospital's financial statements and the Financial Elements Report are to be reconciled per N.J.A.C. 8:31B-4.131.

(c) Other operating expenses and revenues and non-operating revenues are to be categorized below as:

1. [Excluded] Separately reported health care services;

2. – 6. (No Change.)

8:31B-4.62 [Excluded] Separately Reported Health Care Services

(a) Non-Acute Care Services provided by a hospital such as skilled nursing facilities (approved or unapproved); intermediate care facilities, residential care, [long term] psychiatric care, [long term] and comprehensive rehabilitation [and intermediate care] services are not properly acute hospital functions, and hence are [excluded] separately reported and treated as Case C. Sufficient accounting records should be maintained to account for the costs of such operations [(i.e., Medicare cost funding SSA-2552 or SSA-2551)] and such costs should be excluded from Costs Related to Patient Care by cost center per N.J.A.C. 8:31B-[3.19(c) and] 3.24.

(b) Organ Donations: Organs acquired by a hospital and donated to a pool or patient at another hospital are not properly service related to care of patients at the donating hospital, and hence costs and revenues are not included in the service definitions. [The acquisition costs incurred should be accounted for in accordance with the definition of the Organ Acquisition cost center (see N.J.A.C.

8:31B-4.97) but not reported therein. However, c]Costs of such donated organs are applied as increases to Costs Related to Patient Care and Revenues are applied as offsets (Case B).

(c) Blood: In order to encourage hospital solicitation of blood donations, the purchase cost of whole blood or the equivalent units of blood extender and/or plasma are [excluded] separately reported and treated as Case C.

(d) – (e) (No Change.)

(f) [Excluded] Separately Reported Ambulatory Services: Outpatient Renal and Home Dialysis. The cost and revenue related to these services are to be treated as Case C. Sufficient accounting records should be maintained to account for the costs of such operations [(that is, Medicare cost report HCFA-2552)] and such direct and indirect costs shall be excluded from Costs Related to Patient Care.

(g) [Excluded] Separately Reported Ambulatory Services: HealthStart Maternal Care Health Support Services. The revenues and expenses associated with the provision of these services shall be treated as Case C, netted against each other.

(h) [Excluded] Separately Reported Ambulatory Services: HealthStart Pediatric Continuity of Care. In Hospitals with salaried pediatricians, revenues and expenses associated with non-institutional Medicaid capitated fee shall be treated as Case C and netted against each other.

(i) Mobile Intensive Care Unit (MICU) Services provided after November 1, 1987: The cost and revenue related to these services are to be treated as Case

C, revenues and expenses are netted. Sufficient accounting records should be maintained to account for the costs of such operations [(that is, Medicare cost report HCFA-2552)] and such direct and indirect cost shall be excluded from Costs Related to Patient Care.

8:31B-4.64 Sales and services not related to patient care

(a) (No Change.)

(b) Sale of Medical Supplies (other than for an episode of hospital care) to patients such as take-home drugs, excluding those items where it would be medically unreasonable to limit the patient's use to the episode of hospital care, and others are excluded. Take-home supplies for renal dialysis and home health care are included where included in the provisions of [Medical] Medicare [HIM-29 and HIM-11] manuals at www.CMS.hhs.gov/manuals (Case A).

(c) – (i) (No Change.)

8:31B-4.67 Non-operating revenues (net of expenses)

(a) – (e) (No Change.)

(f) Unrestricted Donations, net of [Funding Raising] Fundraising Costs, are not to be included as Revenue Related to Patient Care and treated as Case C.

(g) – (j) (No Change.)

8:31B-4.72 Medical-Surgical Acute Care Units (MSA)

(a) Function:

1. – 2. (No Change.)

3. Functions include serving and feeding of patients; collecting sputum, urine[;]**,** and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of beds; observing patients for reaction to drugs; administering specified medication; infusing I.V. fluids, answering to patients' call signals; and keeping patients' room (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

8:31B-4.82 Clinics (CLN)

(a) Function:

1. (No Change.)

2. This center should include the costs and revenues associated with operating organized clinics for all purposes. Examples of organized clinics include Alcoholism, Dental, Diagnostic, Diabetes, Drug Abuse, Employee Health, ENT, Health Centers, General Clinic, Guidance Counseling, Obstetrics/Gynecology, Ophthalmology, Pediatrics, Physical Medicine, Psychiatric Day Care and Speech. The costs and revenues associated

with an organized Ambulatory Renal Dialysis Unit should be reported in the Dialysis (DIA) center. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55. The cost and revenue of operating clinics that are a branch of the institution are included in Clinics (CLN).

3. (No Change.)

(b) (No Change.)

8:31B-4.83 Off-Site Health Services (OHS)

(a) (No Change.)

(b) A home health agency provides care to patients normally at their place of residence in accordance with the definition of services contained in Medicare [HIM-11] manuals at www.CMS.hhs.gov/manuals. Expenses and revenues of ancillary services performed at homes of patients serviced under a home health program should be reported in the appropriate ancillary service center.

[PART V. DEFINITION OF COST AND REVENUE CENTERS]

8:31B-4.88 Dialysis (DIA)

(a) Function: Dialysis is a hospital based service employing the use of an artificial kidney machine for cleansing the blood. Dialysis includes both hemodialysis and peritoneal dialysis procedures. The inclusion of Dialysis take-home supplies, if not individually charged, and other costs and revenues is in

accordance with Medicare [HIM 29 instructions] manuals at www.CMS.hhs.gov/manuals. Dialysis take-home and other supplies individually charged for are to be reported in Medical and Surgical Supplies Sold, whether sold or rented, if such supplies are included per Medicare [HIM 29] manuals.

(b) (No Change.)

8:31B-4.89 Drugs Sold to Patients (DRU)

(a) Function:

1. (No Change.)

2. Medically prescribed food supplements, if charged directly to patients are included in Drugs Sold to Patients. Cost and revenue associated with blood (i.e., whole blood and packed red cells) and blood components (i.e., fibrinogen, gamma globulin) are to be excluded from the Laboratory center and reported as a reconciliation per N.J.A.C. 8:31B-4, [Part IV] and N.J.A.C. 8:31B-4.91. Excluded from this center are the cost and revenue associated with drugs furnished to a patient for use after his episode of hospital care (except for those items where it would be medically unreasonable to limit the patient's use to the episode of hospital care). Included in the center are the cost and revenue associated with drugs and I.V. solutions sold under renal dialysis and home health agency programs as specified in Medicare [HIM 29 and HIM 11] manuals at www.CMS.hhs.gov/manuals.

8:31B-4.92 Medical and Surgical Supplies Sold (MSS)

(a) Function:

1. (No Change.)

2. Excluded from this center are the cost and revenue associated with supplies furnished to a patient for use after his episode of hospital care (except for those items where it would be medically unreasonable to limit the patient's use to the episode of hospital care, e.g., pacemakers, permanent prostheses, etc., and take-home Dialysis and Home Health Agency supplies included per Medicare [HIM 29 and HIM 11] manuals at www.CMS.hhs.gov/manuals.) Rather, the costs and revenues associated with such items are to be reported as reconciliations per instructions in N.J.A.C. 8:31B-4, [Part IV].

8:31B-4.95 Other Physical Medicine (OPM)

(a) Function:

1. Occupational therapy is the application of purposeful, goal-oriented activity, under the direction of a registered therapist and medical director, in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum[,] functioning, to prevent disability, and to maintain health. Recreational therapy is the employment of sports, dramatics, arts and

other recreational programs, under the direction of a registered therapist and medical director to stimulate the patient's recovery rate.

i. – ii. (No Change.)

2. (No Change.)

8:31B-4.108 Laundry and Linen (L & L)

(a) Function: Laundry and Linen is responsible for the requisitioning, laundering, distribution, control and mending of linen, bedding, wearing apparel, and disposable linen substitutes used by the institution. The purchased cost and maintenance of all wearing apparel, as well as all linen, bedding, etc. are included. The cost of providing laundry and linen services to non-acute care units (see N.J.A.C. 8:31B-4.62 through 4.66) and for the room and board of employees, students, and others (N.J.A.C. 8:31B-4.62 through 4.66) should not be included in this center but reported per N.J.A.C. 8:31B-4.131.

(b) (No Change.)

8:31B-4.118 Administrative and General (A&G)

(a) Function:

1. (No Change.)

2. Administrative and General Services include:

i. Governing Board;

ii. Office of Hospital Administrator Medical Administration;

iii. Medical Administration;

iv. Nursing Administration (persons responsible for more than one functional center);

v. Personnel;

vi. Public Relations;

vii. Communications;

viii. Management Engineering;

ix. Health Sciences Library;

x. Auxiliary Groups;

xi. Travel;

xii. Purchasing and Stores;

xiii. Motor Pool;

xiv. Postage;

xv. Medical Library;

xvi. Medical Photography and Illustration;

xvii. Licenses and Taxes (other than income taxes and payroll taxes);

xviii. Insurance (other than Malpractice and Employees Fringe Benefits);

xix. Security;

xx. Planning;

xxi. Professional Association Memberships;

xxii. Legal and Audit Fees;

xxiii. Duplicating and Printing;

xxiv. Collection Agency Costs